

Kentucky Cabinet for Health and Family Services

Medicaid 1915(c) HCBS Case Management Service Authorization Frequently Asked Questions (FAQs)



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Section 1: Document Background

The Department for Medicaid Services (the Department), on behalf of the Cabinet for Health and Family Services (the Cabinet), is publishing this Frequently Asked Questions (FAQs) document to provide timely updates and responses to stakeholder questions about the Case Management-initiated service authorization policy that took effect on November 25, 2019. These questions were collected from the Service Authorization Webinar held on October 17, 2019, regional Service Authorization Question and Answer Sessions, and questions sent to the 1915(c) Waiver Help Desk. The Department has modified some questions from the originally submitted language to be as clear as possible and not share case-specific details.

We thank you for your continued interest in the 1915(c) HCBS waivers, case management and person-centered service planning redesign. We value your feedback and consider it an important part of the waiver redesign project.

If you have additional questions about case management and/or service authorization, please contact the 1915(c) Waiver Help Desk via email 1915cwaiverhelpdesk@ky.gov or by phone at 844-784-5614.

If you have technical questions about the Medicaid Waiver Management Application (MWMA) or need help navigating the system, please call the MWMA Contact Center at 1-800-635-2570.

If you have comments or questions about 1915(c) waiver redesign, please email medicaidpubliccomment@ky.gov or call (502) 564-7540.

Section 2: Questions and Responses

Q1: Will the functional assessment tell a case manager the services and amounts to request?

Date Added/Revised: 11/26/19

No. The functional assessment alone is not a sole-source of information on an appropriate service or amount of services necessary to advance a participant's person-centered plan goals and service preferences. Case managers will use the information collected via each waiver's functional assessment tool to inform person-centered service plan (PCSP) development. Other documentation, such as observed needs not included in the functional assessment, and participant-expressed goals and preferences should also be used to inform PCSP development and the services included in it, along with the scope, amount, frequency and duration of services appropriate to advance person-centered plan goals and objectives.

A case manager is expected to review the participant's assessment information to gain understanding of his or her comprehensive health status and their functional and daily living needs. Services authorized in a PCSP should align with the participant's assessed needs, intensity of those needs, goals, and preferences.

Q2: What functional assessments are case managers reviewing to justify the services they authorized?

Date Added/Revised: 11/26/19

The functional assessments used in the 1915(c) waiver programs include:

- Acquired Brain Injury (ABI), Acquired Brain Injury Long-Term Care (ABI LTC), Michelle P. Waiver (MPW)
 - MAP-351
- Model II Waiver (MIIW)
 - MAP-351A
- Home and Community Based (HCB) Waiver
 - Kentucky Home Assessment Tool (K-HAT)
- Supports for Community Living (SCL) Waiver
 - Support Intensity Scale (SIS)

Q3: How should a case manager handle SCL allocations where the individual will not have a SIS until they have two respondents who have known them for 90 days?

Date Added/Revised: 11/26/19

Case managers should enter the PCSP requesting services based on the needs of the participant as identified by the case manager. The PCSP can be requested for 120 days. If an extension is needed, please contact the Department for Behavioral Health, Developmental and Intellectual

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Disabilities (DBHDID).

Q4: If additional services are needed but not supported in the functional assessment, where does the additional documentation go?

Date Added/Revised: 11/26/19

Case managers can add justifications for services not supported by the functional assessment to the service notes, by uploading a document, or by ensuring it is reflected in the participant's goals and objectives.

Q5: What happens when a participant needs emergency waiver services?

Date Added/Revised: 11/26/19

There should be a team meeting between the case manager, participant, and the provider(s) who will be providing the service(s). The participant's legal guardian and/or authorized representative should be aware of the meeting, and participate if possible. If the legal guardian/authorized representative does not respond to requests to attend a service planning meeting, case managers should document that in the case notes.

Q6: What happens if a participant's service needs change?

Date Added/Revised: 11/26/19

Case managers should modify the PCSP when service needs change, documenting the nature of the change and what is driving the change in the case notes. The case record should include justification and/or documentation as to why the services needs have changed. If the participant is dis-enrolled and a resume services task is requested, MWMA will generate a new assessment task.

Q7: What does it mean when the case manager receives a notification in their message center that a PCSP is "current"?

Date Added/Revised: 11/26/19

"Current" does not mean the PCSP is approved. It is the responsibility of the case manager to confirm if services were approved, partially approved, or denied.

Q8: Will a case manager know when a participant is denied LOC upon recertification?

Date Added/Revised: 11/26/19

Yes, this information is available in MWMA.

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Q9: What are SMART goals? Will case managers receive training about them?

Date Added/Revised: 11/26/19

Goals and objectives on a PCSP should be SMART:

- **S** Stated Clearly: The goal or objective should be understandable to the participant and in his/her own words;
- **M** Measurable: There should be markers of progress toward achieving a goal or objective that can be identified and quantified;
- **A** Attainable: The goal or objective should be broken into small and actionable steps. Barriers to achieving the goal or objective should be identified and a plan put in place to help mitigate those barriers;
- **R** Relevant: The goal or objective should be important to the participant. Steps toward the goal or objective should help the participant develop and use available resources to achieve it; and
- **T** Time-Bound: There should be a defined period for when the participant is expected to achieve the goal or objective, keeping in mind that reaching the goal or objective can take time and several steps. There should also be an agreed upon schedule in place for checking progress.

Training for case managers is currently being developed with input from Cabinet staff and the Department's Case Management Advisory Subpanel. The Department will release more information about the training as it is finalized. Training is anticipated to occur this Spring.

Q10: It is a challenge to help clients understand their Freedom of Choice when provider options don't exist or when providers try to call the shots. What does the Department recommend in this situation?

Date Added/Revised: 11/26/19

Freedom of choice must be made available to participants and is a federal requirement that case managers must uphold and integrate into options counseling. The Department recognizes that not all areas of the state have multiple service provider options for a participant.

The 1915(c) Waiver Help Desk is available to case managers to report if they believe a service provider is attempting to exert undue influence on the level of services included in a PCSP. This will allow the Department to provide technical assistance and help ensure conflict-free PCSP development, as required by state and federal regulation.

The 1915(c) Waiver Help Desk can be reached at 1915cwaiverhelpdesk@ky.gov or by calling 844-784-5614.

Q11: Will the waivers contain an exceptional unit option for case management? Some clients tend to switch providers more frequently and require a much larger amount of time invested by the case manager.

Date Added/Revised: 11/26/19

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The Department will not offer an exceptional unit for case management services at this time. The Department may consider a tiered payment structure for case management services during future phases of redesign, when more data is available to objectively consider this need and develop a tiered, acuity based payment methodology for case management services. Exceptional supports will continue to be available for applicable services on the SCL waiver. For the exceptional supports process in SCL, please see Provider Letter #A-49

(<https://chfs.ky.gov/agencies/dms/dca/iddcsb/Documents/sclproviderlettera49.pdf>).

Q12: The Service Authorization Training Webinar and Guide states the MAP-350 no longer needs to be uploaded to MWMA. Does it still need to be reviewed and signed by the participant and/or legal guardian annually?

Date Added/Revised: 11/26/19

No, the MAP-350 is no longer required for all six waivers starting November 25, 2019. Case managers are now asked the following yes or no questions in MWMA verifying that they educated participants on freedom of choice:

- “The Individual/Legal Representative has been given a choice between institutional and waiver services and has been given a choice between eligible waivers and providers.”
- “The Individual understands that under the waiver programs, they may request services from any Medicaid provider qualified to provide the service and that a listing of currently enrolled Medicaid providers may be obtained from Medicaid Services.”

Case managers will not be cited during an audit for not having the MAP-350 as auditors are being trained on the new waiver expectations.

Q13: Will there be new forms that participants need to sign?

Date Added/Revised: 11/26/19

No, participants do not need to sign any new forms at this time. Participants still need to sign team meeting documents attesting that they are facilitating the meeting and sign their PCSP to demonstrate that they understand the contents.

Q14: Can case managers alter the team meeting sign-in sheet?

Date Added/Revised: 11/26/19

Case managers may alter the team meeting sign-in sheet, as long as it still captures the date of the meeting, a list of attendees, a signature from each attendee, and their role on the team or relationship to the participant. The Department will share an example of a sign-in sheet from one of our providers has created.

Q15: Can the participant and their family sign the functional assessment?

Date Added/Revised: 11/26/19

Yes, participants and their families in the ABI, ABI LTC, Model II, MPW and SCL waivers may sign the functional assessment to help support the services recommended, however, their signature is not

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required. In the HCB waiver, participants or the participant's legal guardian and/or authorized representative are required to sign the functional assessment, which is the KHAT.

Q16: Will there be a designated team of staff who will be reviewing the PCSPs?

Date Added/Revised: 11/26/19

Yes, the Department will review PCSPs that include high-skill and/or high-cost services. The Department will also regularly review a random selection of PCSPs to monitor for quality and utilization management.

Q17: What if there is a disagreement among the participant, a case manager and/or the identified service provider about the recommended services to be authorized in a PCSP?

Date Added/Revised: 11/26/19

The case manager is ultimately responsible to authorize the services in MWMA and is expected to exercise professional judgment in objectively explaining the level of services considered appropriate, discussing the disagreement with all parties to consider any additional factors that should be considered and entering the authorized level of services into MWMA.

If there is still disagreement with the level of services authorized by the case manager, there is a grievance process in place for disagreements between the case manager and a service provider, the participant and the case manager, or the participant and a service provider. This process allows participants and providers to share their grievance or concern with the Department so an objective third party can review decisions resulting in a disagreement, consider all perspectives and make a final determination.

Q18: If a participant or guardian wants 40 hours, but their plan says they only need 30 hours, how do case managers handle this situation?

Date Added/Revised: 11/26/19

Case managers should document a PCSP that reflects the appropriate level of services based on a participant's assessed and identified needs.

In this instance, the case manager should review the functional assessment information and the contents of the PCSP with the participant and providers. The Department encourages that case managers have a practical discussion with the person-centered planning team to help all parties understand how needed hours are calculated based on the estimated time it would take to complete the components of the PCSP and the scope of services the participant needs. A case manager should also educate a participant and/or their legal guardian/authorized representative that over-stating need for services is considered an act of Medicaid fraud, and that waste and misuse of services can result in negative consequences.

If a participant continues to disagree, he or she may appeal the service authorization through the grievance, reconsideration and appeals process.

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Q19: What happens if the case manager requests, for example, 25 hours, but the representative and employee want more hours and refuse to sign the PCSP?

Date Added/Revised: 11/26/19

The participant should be informed that services cannot be provided without their signature, but that signing the PCSP does not preclude them from filing a grievance over the case manager's determination about the level of services authorized. The representative and employee should document their disagreement on the sign-in sheet and sign it. Case managers should document this and upload the notes into the system.

Q20: How many units of services will a participant receive during the appeal process? For example, if the case management team believes that 20 hours is appropriate, but the participant wants 40 hours.

Date Added/Revised: 11/26/19

During an appeals process, the participant will receive the same number of units that they were receiving prior to the decision resulting in appeal. If the service in question is a new service being added to the PCSP, the participant will receive the lower amount of service units authorized by the case manager until the appeal is decided and a finalized number of services has been authorized. The Department will not be recouping during the appeals process and will send out a letter before the process begins. The Department plans to conduct additional trainings for providers to inform case managers of service delivery standards and person-centered planning when an appeal occurs and is under review.

Q21: How does a participant or provider ask for a reconsideration, file a grievance, or appeal a service authorization decision they disagree with?

Date Added/Revised: 11/26/19

Grievances can be filed by calling the 1915(c) Waiver Help Desk at 844-784-5614 or by emailing 1915cwaiverhelpdesk@ky.gov.

Beginning December 1, 2019, the Cabinet's Office of the Ombudsman will handle reconsideration and appeal requests. More information on this process will be released soon.

Q22: How can case managers assist participants in finding non-waiver resources to support their needs?

Date Added/Revised: 11/26/19

Waiver participants can receive services available through Kentucky's state Medicaid program. For more information on services available through the state Medicaid program, call (502) 564-6890.

The Department's Division of Community Alternatives (DCA) also keeps a list of community resources on its website at <https://chfs.ky.gov/agencies/dms/dca/Documents/resourcelisting.pdf>.

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Q23: Does a case management supervisor need to review every PCSP their case managers complete?

Date Added/Revised: 11/26/19

While not required, case management supervisor review of PCSPs is considered a best practice standard and is encouraged as this new process goes live. If a case management supervisor reviews PCSPs, their review should focus on:

- Use of 1915(c) waiver or non-waiver services
- Frequency of services
- Amount of services
- Appropriateness of goals

More information about case management supervisor reviews of PCSPs can be found on page 16 of the Service Authorization Training Guide at <https://chfs.ky.gov/agencies/dms/dca/Documents/serviceauthorizationtrainingguide.pdf>.

Q24: Is MWMA changing as a result of the updated service authorization policy? Will the changes clog MWMA?

Date Added/Revised: 11/26/19

MWMA users should not notice a significant difference in the look and functionality of the application. While some back-end tasks have changed, the input should look the same for you as it has in the past.

Some changes made to support case management-initiated service authorization include:

- Immediate feedback on the disposition of submitted services that are entered and authorized.
- A more comprehensive prior authorization letter with all three disposition choices divided into three sections: approved, denied, and pending.
- A question about participant choice on the “Submit Plan” page to replace the MAP-350, which will no longer be required as of November 25, 2019.

Changes made are not expected to slow the system or lead to “clogs.” The Department is currently testing and inundating MWMA to make sure systems changes are operating efficiently.

Q25: Will there be a quick reference guide (QRG) for the MWMA functionality updates? Will the QRG be emailed or put on the website? Will there be any training around MWMA?

Date Added/Revised: 11/26/19

The Department released several QRGs for MWMA on November 20, 2019. They are posted in TRIS, along with other case management resources. Additionally, the QRGs are on the Department’s Division of Community Alternatives (DCA) website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

If case managers need access to TRIS, have technical issues with MWMA, or need help navigating

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the application, they can call the MWMA Contact Center at 1-800-635-2570. There will not be MWMA training for updates to the service authorization process since the majority of the changes were made behind the scenes.

Q26: How will MWMA and the Medicaid Management Information System (MMIS) work together?

Date Added/Revised: 11/26/19

MWMA sends service information to MMIS. Case managers will receive either a PA number or an error response. If there is an error response, please read it carefully as it will include information on who to call to for a resolution.

Q27: What services will need to go to the Cabinet? If the PCSP contains one service requiring a Cabinet-level review, will all services on that PCSP need review?

Date Added/Revised: 11/26/19

Clinical and high cost services need to be submitted to the Cabinet for prior authorization. A list of these services can be found in the following documents:

- a. [October 17, 2019, Service Authorization Webinar Recording and Presentation](#)
- b. [What Does this Mean to Me? Service Authorization Changes](#)
- c. [Service Authorization Training Webinar Recording](#)
- d. [Service Authorization Training Guide](#)

The Cabinet will only approve services on a PCSP that require a Cabinet-level review. Case managers will receive immediate feedback on all other services not requiring a review.

Q28: When a PCSP includes case manager-approved services and services requiring a Cabinet-level review, will I receive two letters? What will the PCSP say in this situation?

Date Added/Revised: 11/26/19

The case manager may receive two letters, depending on the timing of the approvals. The first letter may list the case manager-approved services and classify services that are with the Cabinet for review as “pending.” An updated letter is sent after MMIS returns a prior authorization.

The PCSP will show case manager-approved services as “approved.” Services requiring a Cabinet-level review will say “pending.”

Q29: Can PCSPs be backdated?

Date Added/Revised: 11/26/19

The Department will continue to allow back-dating, however, it is not encouraged. When the quality improvement organization (QIO) approved PCSPs, case managers were permitted to back-date up to

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14 days from the PCSP submission date. Under the updated service authorization process, this is increased to 30 days from the submission date.

In MWMA, any new service added to the PCSP that is backdated more than 30 days will require a Cabinet-level review. Any new service backdated 30 days or less will not require a Cabinet-level review, as long as it is a case manager-approved service.

After 30 days, the Department will review backdating requests on a case-by-case basis. Should the Department identify a provider who is frequently back-dating, they will be provided technical assistance and/or receive corrective action. We will also monitor this process through quality monitoring to ensure services are not starting prior to discussions about freedom of choice or the person-centered planning team meeting.

Q30: When and how should the case manager check a participant's financial eligibility?

Date Added/Revised: 11/26/19

Medicaid eligibility is "month pure," meaning when a participant has eligibility at the beginning of the month they will keep it until the end of the month. Case managers should check eligibility at the beginning of the month or prior to providing a service.

Q31: How does a case manager know someone is at risk of losing their waiver services due to financial ineligibility?

Date Added/Revised: 11/26/19

Case managers will find a message in red on the MWMA individual summary screen telling them to call the Department for Community Based Services (DCBS). Participants have 90 days to have their eligibility corrected to a type of assistance (TOA) that supports waiver services. If they do not, they will be dis-enrolled from the waiver.

Q32: When a participant loses eligibility, can a case manager prevent them from being dis-enrolled?

Date Added/Revised: 11/26/19

Participants have 90 days to have their eligibility confirmed prior to dis-enrollment. If a participant is actively trying to get their Medicaid re-instated, please contact the 1915(c) Waiver Help Desk at 844-784-5614 or by emailing 1915cwaiverhelpdesk@ky.gov. The Department will review the situation and may cancel the program closure and provide additional time for the participant to regain eligibility.

Q33: What happens when a participant loses Medicaid eligibility and is dis-enrolled from the waiver?

Date Added/Revised: 11/26/19

Issued prior authorizations and level of care (LOC) will end on the date the participant loses financial eligibility. This process has not changed and will continue to work as it does today.

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Q34: What can be done if a participant is dis-enrolled from the waiver and it is not their fault?

Date Added/Revised: 11/26/19

If the dis-enrollment is the result of a system or agency error, the Department will review these on a case-by-case basis and consider back-dating services to close any gaps. Please include the reason for the gap in your service comments.

Q35: What if a participant is showing up as enrolled in a Managed Care Organization (MCO)?

Date Added/Revised: 11/26/19

If a participant is listed as enrolled in an MCO, they do not have the TOA required to receive 1915(c) waiver services. The case manager or the participant/legal guardian/authorized representative should contact DCBS at 855-306-8959 and let them know the participant is on a long-term care waiver.

Q36: Do case managers need all person-centered planning team signatures for a PCSP modification?

Date Added/Revised: 11/26/19

No, signatures are only required for the parties involved in requesting the modification. The only exception is modification of behavioral services which requires all team members to sign, including service providers. Alternative documentation, such as phone calls, etc., will still be acceptable.

Q37: If a modification is made to the PCSP, what will the prior authorization letter look like?

Date Added/Revised: 11/26/19

The case manager, the participant, and the direct service provider affected by the PCSP modification will receive a letter. The letter will list all services, including those that were not modified.

Q38: Who has access to a participant's prior authorizations? Where will providers find prior authorizations?

Date Added/Revised: 11/26/19

Prior authorization letters will be generated by MWMA and available in the individual's message center. All providers receive a mailed copy of the prior authorization letter which will be divided into three sections: approved, denied, and pending.

MWMA includes a new button case managers can use to view a PA letter as long they have at least one prior authorized service. This button is called "Generate PA Letter" and is located on the "Manage Plan" screen. This will show the most current information, however, it will not show PA numbers.

Providers can use MMIS to view prior authorization numbers and details (such as whether a service is approved, denied or pending), however, MMIS will no longer show provider authorization letters. To

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view prior authorization numbers and details in MMIS, use “PA Inquiry.” Instructions can be found here: <https://chfs.ky.gov/agencies/dms/dca/Documents/painquiryinstructions.pdf>.

Q39: How will billing reviews be conducted?

Date Added/Revised: 11/26/19

The Department is working on standardizing billing review processes across all waivers. Proposed changes include performing desk-level billing reviews since the information is available in MWMA.

Q40: If technical assistance is given, will there be a recoupment?

Date Added/Revised: 11/26/19

While the Department will initially focus on technical assistance to help support the shift to case management-initiated service authorization, the Department reserves the right to issue recoupment for willful and intentional violations of state or federal regulation and will continue to uphold and enforce program rules and requirements.

Q41: Having case managers authorize services puts them at risk with providers and participants. They must advocate for their participant, but sometimes receive pressure from providers to request the maximum number of services. How do case managers avoid getting caught between the participant and provider?

Date Added/Revised: 11/26/19

It is the position of the Department that a provider should not dictate the number of hours provided to fulfill a PCSP nor who provides services to a participant. Participants have freedom of choice in selecting providers, with the exception of observing rules for conflict-free case management that disallow receipt of case management and direct services from the same provider. Services should be based on assessed need, as well as the participant’s goals, objectives, and preferences. While a service provider should have input as part of the person-centered planning team, services should not be based on how many hours a provider wants, nor should participants be told they must receive all services from the same provider. If a case manager is struggling to resolve a disagreement among parties or believes that providers are exerting undue influence, then they should contact the 1915(c) Waiver Help Desk for technical assistance or alert the Department for further review and resolution.

Q42: Will case managers be responsible for the cost effectiveness of PCSPs?

Date Added/Revised: 11/26/19

Yes, monitoring cost-effectiveness of services is not a new role or responsibility. According to the current waiver-related Kentucky Administrative Regulations (KARs) case managers are responsible to monitor implementation of a PCSP for cost-effectiveness on a monthly basis. Case managers are encouraged to review a participant’s documented needs in the functional assessment and determine how best to meet those needs, including looking at appropriate services in the state Medicaid program and engaging community resources.

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Q43: How is a case manager supposed to detect Medicaid fraud, waste, or abuse?

Date Added/Revised: 11/26/19

Considering and monitoring cost-effectiveness of services, ensuring waiver services are appropriate to each participant's assessed and documented needs, and engaging state Medicaid program services and community resources can help reduce instances of fraud, waste and abuse. Any time the case manager suspects Medicaid fraud, waste, and abuse they should report it to the Office of the Inspector General (OIG) by calling 1-800-372-2970.

Q44: Is respite approved for a calendar year?

Date Added/Revised: 11/26/19

No, respite will stay on the state fiscal year calendar (July 1 - June 30). Respite should follow the current waiver-related KARs until the amended 1915(c) HCBS waiver applications and updated KARs are approved and implemented.

Q45: Can E1399 supplies, such as gloves and wipes, be requested through the waivers?

Date Added/Revised: 11/26/19

Yes, wipes and gloves can be requested through the waiver programs.

Q46: How should a case manager enter Financial Management Services for ABI, ABI LTC, and MPW?

Date Added/Revised: 11/26/19

T2040 Financial Management for ABI, ABI-LTC and MPW will no longer be added as a separate service line within the PCSP; therefore, there will also be no separate prior authorization for this service. The Financial Management Agency is selected upon adding any PDS service on the "Service Details" screen of the PCSP.

Q47: Should Occupational, Speech, and Physical Therapy services be requested through the state Medicaid program for MPW participants?

Date Added/Revised: 11/26/19

Occupational, Speech, and Physical Therapy services for MPW participants under the age of 21 should be requested through the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. For more about EPSDT, visit <https://chfs.ky.gov/agencies/dms/dpqo/dcmb/Pages/epsdt-screenings.aspx>.

Occupational, Speech, and Physical Therapy services for MPW participants older than 21 can still be requested through the waiver. In the amended 1915(c) HCBS waivers, the Department is proposing to transition these services to the state Medicaid program for MPW participants older than 21, however, this change will not take effect until the amended waivers have been approved by the Centers for

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Medicare and Medicaid Services (CMS). The Department does not anticipate this to happen until mid-2020.

Q48: In MPW, who can receive Goods and Services? Is it only for participants using PDS?

Date Added/Revised: 11/26/19

Currently, Goods and Services is only a PDS service in MPW.

Q49: In the Service Authorization Training, the Department lists “Billing for services when the participant is in an alternate care setting or out of state” as an example of fraud, waste, and abuse. According to a Department letter issued in October 2018, billing for services out of state is an acceptable practice. Can you clarify?

Date Added/Revised: 11/26/19

The guidance issued via provider letter on October 25, 2018 (<https://chfs.ky.gov/agencies/dms/ProviderLetters/pdstravelupdate.pdf>) pertains to instances where a waiver participant living in Kentucky travels out of state for a temporary period of time, such as visits to family or trips to attractions. The situation would be considered fraud if the participant is receiving services while residing outside of the state.

Q50: How do case managers bill the case management service in HCB and MPW?

Date Added/Revised: 11/26/19

For MPW, case managers should use the date of their face-to-face meeting with a participant as the date of service. There should be documentation supporting this. Bill the number of units indicated on your prior authorization.

For HCB, case managers should request one unit and it will reimburse at the max or lesser of billed charges. Instead of requiring you to bill multiple units each month, you can bill one unit and receive up to the full reimbursement.

Q51: When will the Service Authorization Standard Operating Procedure (SOP) and Service Authorization Crosswalks be released?

Date Added/Revised: 11/26/19

The Department released the Service Authorization SOP and the Service Authorization Crosswalks on November 19, 2019. They are available on the Department’s DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

Q52: Will there still be *lack of information* (LOI) requests

Date Added/Revised: 11/26/19

Yes, if the Department receives a request with insufficient information. The participant and his or her legal guardian and/or authorized representative will also receive a letter. This letter will also be

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available in the participant's message center in MWMA. The case manager will receive a notification in their message center as well.

Q53: Until the LOC process is changed, how long will it take the Department to do the review?

Date Added/Revised: 11/26/19

The Department is targeting to keep the reviews within three (3) business days, but it may take longer at first as staff adjust to process changes and shifts in day-to-day volume.

Q54: If the case manager makes an error in the drop down box, how do they fix it?

Date Added/Revised: 11/26/19

MWMA will provide immediate feedback via either an approval or an error message. At that point, the case manager can cancel what is inputted as long as there is not a prior authorization attached. This will cancel the entire service and a new line will need to be submitted.

Once a prior authorization is attached, case managers will need to request a void from the Department. A void can only be completed when no claims have been paid against the service.

To request a service line be voided, case managers should send an email to 1915cwaiverhelpdesk@ky.gov with "Void" in the subject line. When a case manager is notified that a PCSP is in a "current" status, he or she should review each service for the determination results. It is important to review the PCSP and remember that a "current" status doesn't mean "approved."

Q55: Will there be changes to exceptional supports on the SCL waiver?

Date Added/Revised: 11/26/19

No, currently there are no changes to exceptional supports. The exceptional supports process for the SCL waiver can be found in provider letter #A-49 (<https://chfs.ky.gov/agencies/dms/dca/iddcsb/Documents/sclproviderlettera49.pdf>).

Q56: What happens if a case manager requests inappropriate services?

Date Added/Revised: 11/26/19

Any recoupment issued will be connected to the provider delivering the service in question. If the Department identifies that a case manager requested inappropriate services, we will provide technical assistance and reserve the right to issue corrective action. Justification for services should be documented if they are not supported by the functional assessment. Service notes should support the amount of services provided. Knowingly misrepresenting the level of need or services in the PCSP and authorizing an inappropriate level of service is considered an act of Medicaid fraud.

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Q57: There have been instances when service requests were entered and warranted, but it took months to find an appropriate caregiver. Will that cause an issue?

Date Added/Revised: 11/26/19

Technically, if a participant is not receiving any services, they should be discharged from the waiver after 60 days. A case manager should document challenges identifying a service provider and contact the Department via the 1915(c) Waiver Help Desk by emailing 1915cwaiverhelpdesk@ky.gov or by calling 844-784-5614 for further assistance.

Q58: Is there training on the updated service authorization policy available for direct service providers?

Date Added/Revised: 11/26/19

Direct service providers can take the same training offered to case managers. The Service Authorization Training and Service Authorization Training Guide is available on the Department's Division of Community Alternatives webpage at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>.

Q59: What communication has been provided to participants about this service authorization policy update?

Date Added/Revised: 11/26/19

The Department issued a letter for participants on November 22, 2019. The letter is available via the following link <https://chfs.ky.gov/agencies/dms/dca/Documents/serviceauthforparticipants.pdf>.

Q60: Did the Case Management Advisory Subpanel consider this updated service authorization policy?

Date Added/Revised: 11/26/19

Yes, the Department's Case Management Advisory Subpanel provided input on updates to service authorization. The subpanel's meeting minutes are available at <https://chfs.ky.gov/agencies/dms/dca/Documents/hcbsapandsubpanelinfodoc.pdf>.

Q61: The Department recently proposed updated rates for case management services across waivers. Will these rates and the service authorization policy update take effect at the same time?

Date Added/Revised: 11/26/19

No, rates are not changing during the service authorization implementation process. The updated rates are part of proposed changes to appendices C, I and J of the amended 1915(c) HCBS waiver applications. The Department is accepting official public comment on updates to those appendices until December 10, 2019. The proposed rates can be viewed in the amended waivers and in the

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“What Does This Mean to Me?” documents available on the Department’s DCA website at <https://chfs.ky.gov/agencies/dms/dca/Pages/default.aspx>. If you would like to make a comment about the rates, please email medicaidpubliccomment@ky.gov.